Benefit Plans

HB 1895 gives the Board flexibility to define the benefit plans offered, with the following constraints:

- The HRP must offer at least 2 PPO-style benefit plans having different deductible and cost sharing levels, and at least 1 HSA (health savings account).
- At least 2 of the offered plans must cover no less than the benefits and services listed in the NAIC Model Law, and be consistent with comprehensive insurance plans generally available in the market.
- All benefit plans must include disease management or case management services. It is notable that disease management and case management are two different services, and it may be in the State's best interest to require both. Disease management refers to long-term care management of patients having chronic diseases (e.g., diabetes, hypertension, asthma). Case management commonly refers to short-term management of acute conditions (e.g., heart attack, cancer, burns, or other accidents). Disease management and case management both strive to improve patient health status and to eliminate unnecessary healthcare expenditures.
- Lifetime benefit maximums must not be less than $1 million. Limits in other states range from a low of $500,000 (Idaho Basic plan, Louisiana, Mississippi, Oklahoma, and Wyoming Brown Plan) to a high of "unlimited" (Indiana, Kentucky Standard Benefit Plan, and New Mexico). 16 states have at least one plan having a lifetime benefit limit of $1 million.
- Annual out-of-pocket spending limits must not be more than $5,000, which presumably includes the deductible and all coinsurance and copays paid by the member. There is a wide range of limits in other states. $5,000 falls approximately in the middle of the range; however most states have at least one option with a greater out-of-pocket limit.

HB 1895 says that "limitations" will be adjusted at least every 5 years to reflect inflation. The bill seems to be referring to the out-of-pocket spending limit and the lifetime benefit limit. Ideally, other fixed-dollar cost sharing amounts, such as deductibles and copays, should also be adjusted.

The model law lists specific requirements for some services that tend to not be universally covered by individual health plans. For example, prescription drugs must be covered. Services that may be excluded from coverage include:

- Dental care, with specific exceptions.
- Eyeglasses.
- Hearing aids.
- Routine physical exams and associated tests.
- Infertility treatments.